CHAPTER 6: COMPETITION LAW: INSURERS

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I. INTRODUCTION

In the health insurance industry, health insurers are both sellers of insurance to consumers and buyers of medical services. As a result, mergers and other conduct involving health insurers potentially can raise issues related to both monopoly and monopsony power. Chapter 6 discusses some of these issues.

II. MERGERS OF HEALTH CARE INSURERS

As discussed in Chapter 4, the Agencies use the framework provided by the *1992 Horizontal Merger Guidelines* (*Merger Guidelines*)[1] to evaluate whether a merger or acquisition will likely "create or enhance market power or … facilitate its exercise."[2] Market power "is the ability profitably to maintain prices above competitive levels for a significant period of time."[3] As in Chapter 4's discussion of hospital mergers, this Chapter uses the framework of the *Merger Guidelines* to discuss issues that arise in connection with mergers or acquisitions involving health care insurers.

A. Product and Geographic Market Definition

Merger analysis can begin either with an assessment of direct evidence of anticompetitive effects,[4] or the identification of relevant product and geographic markets and the calculation of the shares of market participants and concentration ratios.[5] A relevant market typically is defined as a product or group of products and a geographic area in which the product or groups of products is produced or sold such that a hypothetical profit-maximizing firm, not subject to price

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[1] U.S. DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 0.1 (1992) [hereinafter MERGER GUIDELINES], *available at* http://www.ftc.gov/bc/docs/horizmer.htm.

[2] *Id*. When a group of sellers combines to exercise market power it is called oligopoly power.

[3] *Id.*

[4] *E.g.*, *In re* Schering-Plough Corp., No. 9297, at 16-17 (Dec. 18, 2003) (opinion) (discussing FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 460-61 (1986), in which the Supreme Court said that "the finding of actual, sustained adverse effects on competition … is legally sufficient to support a finding that the challenged restraint was unreasonable even in the absence of elaborate market analysis."), *available at* http://www.ftc.gov/os/adjpro /d9297/031218commissionopinion.pdf. A number of lower court decisions have followed this principle. *See, e.g.*, Todd v. Exxon Corp., 275 F.3d 191, 206 (2d Cir. 2001) (evidence of "an actual adverse effect on competition … arguably is more direct evidence of market power than calculations of elusive market share figures"); Toys R' Us v. FTC, 221 F.3d 928, 937 (7th Cir. 2000) (market power can be proved "through direct evidence of anticompetitive effects"); United States v. Baker Hughes Inc., 908 F.2d 981, 992 (D.C. Cir. 1990) ("'[m]arket share is just a way of estimating market power, which is the ultimate consideration,' and … '[w]hen there are better ways to estimate market power, the court should use them'" (quoting Ball Memorial Hospital v. Mutual Hospital Insurance, 784 F.2d 1325, 1336 (7th Cir. 1986)).

[5] *See, e.g.*, FTC v. H.J. Heinz Co., 246 F.3d 708 (D.C. Cir. 2001); MERGER GUIDELINES, *supra* note 1, § 0.2.

regulation, that was the only present and future producer or seller of those products in that area likely would impose at least a "small but significant and non-transitory" increase in price above the competitive level, assuming the terms of sale of all other products are held constant. A relevant market is a group of products and a geographic area that is no bigger than necessary to satisfy this test.[6] Analysis typically starts with a narrow market, which is broadened until demand-side substitution is sufficient to make the price increase unprofitable.[7]

1. Product Market

In health insurance markets, considerable attention has focused on the definition of the relevant product market.[8] One threshold issue is whether health maintenance organizations (HMOs), point of service plans (POSs), preferred provider organizations (PPOs), and indemnity plans are separate product markets or all part of a single product market.[9] A second issue is whether self-insured employer plans are in the same product market as commercial insurers and health plans. [10]

The first issue arises in deciding whether HMOs and PPOs are separate product markets, either from each other or from a market consisting of all health insurance financing.[11] Until recently, a prominent and common characteristic of many HMOs was the use of a closed panel of physicians with a primary care physician acting as a "gatekeeper," but several panelists noted a pronounced trend toward less restrictive forms of managed care.[12] As a result, several panelists

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[6] MERGER GUIDELINES, *supra* note 1, § 1.0.

[7] *Id.* §§ 1.11, 1.21; Seth Sacher & Louis Silvia, *Antitrust Issues in Defining the Product Market for Hospital Services*, 5 INT'L J. ECON. BUS. 181, 182 (1998).

[8] *See, e.g.*, Monk 4/23 at 38-49; Ginsburg 4/23 at 24-26; Desmarais 4/23 at 36-38.

[9] *See, e.g.*, Monk 4/23 at 43-49; Ginsburg 4/23 at 25; Desmarais 4/23 at 36-38; Lerner 4/23 at 66; Feldman 4/23 at 52-64.

[10] *See, e.g.*, Monk 4/23 at 39-40 (until DOJ's 1999 consent in *United States v. Aetna Inc.*, 1999-2 Trade Cas. (CCH) ¶ 72,730 (N.D. Tex. 1999), the definition of the relevant product and geographic markets for health insurance did not provoke controversy; usually, the relevant geographic market was at least statewide, and the relevant product market included self- and fully-insured products, as well as HMOs, PPOs, and indemnity plans); Ginsburg 4/23 at 26; Desmarais 4/23 at 42; Feldman 4/23 at 61-64.

[11] The following analysis deals with group comprehensive medical insurance and may not be applicable to assessing transactions or practices involving individual comprehensive medical insurance, worker's compensation, disability, long-term care, or dental insurance. *See, e.g.*, Desmarais 4/23 at 32 ("From our perspective, it's important to realize that there's really two distinct markets. There's a group market for health insurance, as well as an individual market. The two markets vary considerably in terms of the economic, business and regulatory considerations and we need to keep that in mind."); Feldman 4/23 at 56-57 (medicare health plan market may be distinct from employer health plan market).

[12] Ginsburg 4/23 at 21; 25-26; Desmarais 4/23 at 36-37; Monk 4/23 at 43-45; Lerner 4/23 at 67-68, 70-73. *See also supra* Chapter 1.

suggested that the relevant product market should be defined broadly.[13]

Two Seventh Circuit cases, *Blue Cross & Blue Shield v. Marshfield Clinic*[14] and *Ball Memorial Hospital v. Mutual Hospital Ins., Inc.*,[15] suggest that HMOs and PPOs are not, and cannot be, separate markets. The Seventh Circuit indicated in both cases that HMOs and PPOs are instead part of a larger health insurance financing market.

In *Marshfield Clinic*, Blue Cross & Blue Shield (Blue Cross) and their subsidiary HMO alleged that the Marshfield Clinic, a physician-owned clinic, and its HMO had monopoly power in the HMO market that they had acquired and maintained through improper practices.[16] The Seventh Circuit rejected the argument that HMOs constituted a relevant product market separate from other forms of health care coverage. The court stated that "[a]n HMO is basically a method of pricing medical services," and not a distinctive organizational form or group of skills.[17] The court noted that Blue Cross's ability to contract with enough physicians to form a PPO network in the same geographic area in which it alleged the Marshfield Clinic had a monopoly implies that Blue Cross also had the ability to form an HMO.[18] The court concluded that "services offered by HMOs and by various fee-for-service plans are both provided by the same physicians, who can easily shift from one type of service to another if a change in relative prices makes one type more lucrative than others."[19]

In *Ball Memorial Hosp. Inc. v. Mutual Hospital Insurance*, eighty acute care hospitals alleged that Blue Cross's attempt to offer a PPO plan violated the antitrust laws because Blue Cross had market power and abused it.[20] The hospitals were concerned that if Blue Cross entered the PPO market, it would exercise monopsony power by lowering the prices it paid to participating hospitals.[21] The hospitals also were concerned that once Blue Cross lowered the prices it paid for their services, the hospitals would be forced to charge higher prices to other PPOs, including their own, which would allow Blue Cross to raise the costs of, and take business

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[13] *See, e.g.*, Lerner 4/23 at 66-73; Monk 4/23 at 42-44, 48.

[14] 65 F.3d 1406 (7th Cir. 1995) (Posner, C.J.).

[15] 784 F.2nd 1325 (7th Cir. 1986) (Easterbrook, J.).

[16] *Marshfield Clinic*, 65 F.3d at 1407.

[17] *Id.* at 1409.

[18] *Id.* at 1410.

[19] *Id.* at 1411.

[20] *Ball Mem'l Hosp.*. 784 F.2d at 1330-31.

[21] *Id.* at 1331, 1339-40.

away from, competing PPO plans.[22]

The Seventh Circuit held that market power was a prerequisite to any finding that Blue Cross violated the antitrust laws and upheld the district court's finding that Blue Cross did not have market power. Blue Cross's lack of market power was based in large part on the district court's finding that the product was health care financing, and that the "Blues, other insurance companies, hospitals offering PPOs, HMOs, and self-insuring employers all offer methods of financing health care."[23]

As in all industries, the specific facts of each matter must be carefully evaluated to determine the parameters of health insurance markets.[24] One panelist explained that "it's important to keep an eye on the ball and remember that the question is not, is there a price difference between HMO products and PPO products and … whether there are attribute differences between the products. The question is, assuming a competitive equilibrium in both and then the competitive equilibrium disappeared in one of them so that then somebody tried to raise price, would the change in relative price drive

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[22] *Id.* at 1331, 1338-40 (the hospitals raised issues about cost-shifting and cross-subsidization in this context). See *supra* Chapter 3 for further discussion of this issue.

[23] *Ball Mem'l Hosp.*. 784 F.2d at 1331, 1340. The court also stated that the "insurance industry is not like the steel industry, in which a firm must take years to build a costly plant before having anything to sell. The 'productive asset' of the insurance business is money, which may be supplied on a moment's notice, plus the ability to spread risk, which many firms possess and which has no geographic boundary." *Id.* at 1335.

[24] In *U.S. Healthcare, Inc. v. Healthsource, Inc*., 986 F2d 589, 598-99 (1st Cir. 1993), the First Circuit affirmed the trial court's rejection of an HMO-only market in favor of one that includes all forms of health care financing. As the court explained:

> The problem with U.S. Healthcare's argument is that differences in cost and quality between products create the possibility of a separate market, not the certainty …. [T]he issue … would be whether a sole supplier of HMO services … could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits. Usage patterns, customer surveys, actual profit levels, comparison of features, ease of entry, and many other facts are pertinent in answering the question.

See also Cont'l Orthopedic Applicances, Inc. v. Health Ins. Plan of Greater N.Y., Inc., 40 F. Supp. 2d 109, 119 (E.D.N.Y. 1999) ("[N]either of those cases [*Marshfield Clinic* and *U.S. Healthcare*], or for that matter, any of the cases cited in the defendants briefs, stand for the proposition that HMOs can never be a separate viable product market.")

consumer response back and forth between the segments."[25]

In *Aetna*, the Division concluded that "[b]y virtue of the benefit design differences, pricing differentials, and other factors, PPOs and indemnity plans are not reasonable substitutes for HMO and HMO-POS products. Neither employers nor employees view[ed] HMOs and PPOs as the same product, and enrollees who le[ft] an HMO disproportionately select[ed] another HMO, rather than a PPO, for their next plan." The Division also concluded that a "small but significant increase in the price of HMO and HMO-POS products would not cause a sufficient number of customers to shift to other health insurance products to make such a price increase unprofitable [and, therefore,] HMO and HMO-POS plans … are an appropriate relevant product market within which to assess the likely effects of the proposed acquisition."[26]

In other investigations conducted both before and after *Aetna*, the Division concluded that the relevant product market was all managed care products, and not HMOs or PPOs separately. As one panelist stated, "[w]e need to study the reactions of health plans, employers and employees as the marketplace evolves. And … any analysis that takes place from here on out needs to factor in the changing marketplace that is emerging due to the managed care backlash."[27]

Another panelist stated that "we should look at the effect of macroeconomic conditions on how to define product markets. There's soft empirical evidence which demonstrates that the price elasticity of demand for HMOs depends on macroeconomic conditions …. It suggests … that the state of the macroeconomic economy might compress the price elasticity during good times, pushing the products possibly into the same market and then pulling them back apart again."[28] This same panelist stated, however, that at this time "[t]here are distinct product markets for different types of health insurance plans, characterized by enrollees' ability to "choose their own doctor," including the ability to see specialist physicians without a referral

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[25] Lerner 4/23 at 67, 73 (noting that all of the litigated cases have defined the market broadly, but that the analysis in many of the cases "is either thin or wrong-headed"). *See also* Arthur Lerner, *Health Insurance Monopoly Issues – Market Definition* 13 (4/23) (slides), *at* http://www.ftc.gov /opp/hc/030423arthurlerner.pdf; Feldman 4/23 at 50-51 (suggesting that the main problem with decision in *Marshfield Clinic* is it defines a product market using both supply and demand substitution, whereas the Guidelines suggest only demand substitution should be considered in defining a relevant product market), 52 (noting that although supply substitution is relevant to antitrust analysis, its use should be limited to identifying firms that participate in the relevant market and to the analysis of entry); MERGER GUIDELINES, *supra* note 1, §§ 1.32, 3.

[26] United States v. Aetna Inc., No. 3-99CV 1398-H ¶¶ 17-18 (June 21, 1999) (complaint) [hereinafter *Aetna Complaint*], *available at* http://www.usdoj.gov/atr/cases/f2500/2501.pdf; *see also* United States v. Aetna Inc., No. 3-99 CV1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement) [hereinafter *Aetna Impact Statement*], *available at* http://www.usdoj.gov/atr/cases/f2600/2648.pdf.

[27] Monk 4/23 at 49; *see also id*. ("[F]rom the evidence that I've been able to analyze … HMOs and PPOs generally do compete in the same relevant market").

[28] Feldman 4/23 at 60-61.

and to use any hospital recommended by a physician."[29]

The second issue is whether self-insurance should be included as part of the relevant product market.[30] This issue is highly fact-specific, and will turn on the particulars of any given case. One panelist suggested that analyzing "win-loss reports from insurers and switching reports from employers can tease out the level of competition" that self-insurance provides, and stated his conclusion "that both funding types are in the same market."[31] Such reports might also provide insight on product market definition, geographic market definition, and ease of entry.[32]

2. Geographic Market

The Agencies begin geographic market analysis for mergers in this industry with the location of each firm to determine whether the merging firms sell in the same areas.[33] The Agencies then analyze the available facts to assess whether the relevant geographic market is larger or smaller than the candidate market.[34]

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[29] Roger Feldman, *Health Insurance Monopoly Issues – Market Definition* 7 (4/23) (slides), *at* http://www.ftc.gov/ogc/healthcarehearings /docs/030423feldman.pdf; Feldman 4/23 at 52, 53-64 (discussing studies and demand elasticities that support his belief that there are separate product markets and noting that consumer price sensitivity appears to be significant among comparable plans, *i.e.*, is across plans where non-price attributes such as provider network and utilization controls are held constant).

[30] *See, e.g.*, Desmarais 4/23 at 37 ("Obviously, if I'm an insurer and I have an employer customer, I have to be mindful of the fact that that customer, at any time, can decide to become self-insured and to assume the responsibility and hire a TPA, not necessarily my insurance company, and that certainly has to color the relationships between the employer customers and the insurers and TPAs in which they do business.").

[31] Monk 4/23 at 42-43. *See also id.* at 45 (noting that bidding documents and broker spreadsheets also provided useful insights); Feldman 4/23 at 96 (citing Portland, Oregon as an example of why the assessment of self-insurance in the product market has to be geographically specific: "[W]e found that even large employers in the Portland market just don't want anything to do with self-insurance. It's virtually a fully-insured city for reasons that are not entirely obvious to me."). *But see* Lerner 4/23 at 98 (suggesting that although employers in Portland do not self-insure now, they might change their minds if the price of other insurance products went up); Monk 4/23 at 98-99 (noting that perhaps employers in Portland do not self-insure because the other available products are great, but if that were to change, employers might choose to self-insure).

[32] *See* Monk 4/23 at 42, 43 (noting that perhaps self-insurance should not be included in the relevant product market for small employers because such employers may not find it "advantageous to switch to a self-insured plan"). Obviously self-insurance can only be part of the relevant product market if employers view it as a substitute for products offered by commercial insurers.

[33] MERGER GUIDELINES, *supra* note 1, § 1.21. The Division, in some recent cases, has used the United States Department of Commerce Metropolitan Statistical Areas (MSAs) as a starting point for defining geographic markets for insurance company mergers.

[34] *Id. See also* Feldman 4/23 at 90 ("[I]f an HMO … raises its price, would buyers switch to products produced outside the region? … [T]he answer is quite clear, geography matters.").

For example, in *Aetna* the Division alleged that "[t]he relevant geographic markets in which HMO and HMO-POS health plans compete are … no larger than the local areas within which managed care companies market their respective HMO and HMO-POS plans … [because] [p]atients seeking medical care generally prefer to receive treatment close to where they work or live, and many employers require managed care companies to offer a network that contains a certain number of health care providers within a specified distance of each employee's home."[35] The relevant geographic markets in that case were the MSAs "in and around Houston and Dallas, Texas."[36]

B. Competitive Effects

The *Merger Guidelines* describe two main theories of competitive harm: unilateral effects and coordinated interaction.[37] When mergers or acquisitions involving health care insurers have threatened competitive harm, it has more typically been through alleged unilateral effects than through coordinated effects. The likelihood of adverse unilateral effects usually is connected to whether each of the merging firms' products are each others' best substitute.[38] For example, in the *Aetna* case, the Division alleged that "Aetna and Prudential are among each other's principal competitors in the HMO and HMO-POS markets in Houston and Dallas, and are considered by employers to be close substitutes in their product attributes and quality.[39]

Several panelists suggested that the more similar the merging companies are, the more likely the entity could exercise market power post-merger. One panelist presented the results of an empirical study he conducted, in which he compared mergers involving locally-based health plans with those involving national HMOs. He found that these two types of HMOs are very different and that the entry of a national HMO is unlikely to impact significantly the profits or competitiveness of a local HMO, and *vice-versa*.[40] Thus, according to this panelist, in a market

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[35] *Aetna Complaint*, *supra* note 26, ¶ 19. *But see* Monk 4/23 at 41 (arguing that although the *Merger Guidelines* do not use supply substitution to define markets, in his view "the ease and speed with which these [health] plans can move from one part of a state to another make insurance markets an exception").

[36] *Aetna Complaint*, *supra* note 26, ¶ 20; *Aetna Impact Statement*, *supra* note 26, at 7. *See also* Monk 4/23 at 40 ("[M]y experience on more recent mergers suggests that an MSA-based, fully insured HMO market is still the Department of Justice's starting point."); News Release, Dep't of Justice Antitrust Division, Statement on the Closing of its Investigation of Anthem, Inc.'s Acquisition of Wellpoint Health Networks, Inc. (Mar. 9, 2004), *at* http://www.usdoj.gov/atr/public/press_releases/2004/202738.pdf.

[37] *See* MERGER GUIDELINES, *supra* note 1, §§ 2.1, 2.2.

[38] *Id.* § 2.21 ("Substantial unilateral price elevation in a market for differentiated products requires that there be a significant share of sales in the market accounted for by consumers who regard the products of the merging firms as their first and second choices, and that repositioning of the non-parties' product lines to replace the localized competition lost through the merger be unlikely.")

[39] *Aetna Complaint*, *supra* note 26, ¶ 21; *Aetna Impact Statement*, *supra* note 26, at 8.

[40] Mazzeo 4/23 at 133-34, 139-42.

with three local HMOs and two national HMOs, the merger of the two national HMOs might result in significant market power because its effects would be similar to a two to one merger.[41]

Many hearing participants testified that health insurance markets in most geographic areas enjoy robust competition, with "multiple health insurer competitors and several product options, including HMO, PPO, POS, and consumer directed health plans."[42] One panelist explained that "competitors within specific markets vary, including regional and local plans serving specific needs and geographies. There is a wealth of competition for employers' business. Additionally, employers can opt to self-fund their insurance."[43]

Another panelist stated that, although large employers believe that health care markets could be more competitive in quality, service, innovation, and price, they "are generally satisfied with the level of competition among health plans and insurers."[44] She noted that large employers usually can choose from both national health plans and smaller, regional plans to serve their health insurance needs, and that most insurers offer three to four products from which employees may choose.[45] Employers also will conduct periodic assessments and audits and will re-bid or re-negotiate their health insurance contracts if not satisfied.[46] Moreover, "[l]arge employers also have the option to self-fund their benefits, use a carrier or third party administrator to pay claims, [or] contract with networks to get appropriate discounts."[47]

Other panelists stated that health insurance markets are not sufficiently competitive. One panelist presented data indicating substantial insurer and hospital concentration in numerous markets throughout the United States, and stated that this development has had serious

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[41] *Id.* at 142-143. Of course, a health plan merger does not necessarily have adverse unilateral effects just because it is "big." In the Division's recent investigation of the Anthem/WellPoint merger, for instance, the Division learned from employers and other market participants that, in addition to one of the merging parties' market shares being very small in each of the nine states in which they competed, neither of the WellPoint products was a close competitor to Anthem in any of these states. Given these facts, the Division concluded that this transaction would not enhance Anthem's ability to increase prices, reduce quality, or otherwise reduce consumer welfare in any of these markets. Dep't of Justice Antitrust Division, *supra* note 36.

[42] Fred Dodson, *Health Insurance Monopoly Issues – Competitive Effects* 3 (4/23) [hereinafter Dodson (stmt)], *at* http://www.ftc.gov /ogc/healthcarehearings/docs/030423freddodson.pdf. *See also* Dodson 4/23 at 172; Darling 4/23 at 183-84; Helen Darling, *Health Insurance Monopoly Issues – Competitive Effects* 1 (4/23) [hereinafter Darling (stmt)], *at* http://www.ftc.gov/ogc/healthcarehearings /docs/030423darling.pdf; Wu 4/23 at 117; Lawrence Wu, *Economic Issues in Analyzing Competitive Effects in Health Insurance Markets* 4-14 (4/23) (slides) [hereinafter Wu Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030423wucompetitve.pdf.

[43] Dodson (stmt), *supra* note 42, at 3. *See also* Dodson 4/23 at 172; Darling 4/23 at 186.

[44] Darling (stmt), *supra* note 42, at 1. *See also* Darling 4/23 at 183-86.

[45] Darling 4/23 at 183, 185; Darling (stmt), *supra* note 42, at 1.

[46] Darling (stmt), *supra* note 42, at 1.

[47] *Id.*; *see also* Darling 4/23 at 185-87.

implications for premium levels and payments to other providers (*e.g.*, physicians).[48]

C. Entry

The *Merger Guidelines* provide that entry should be considered if it is likely to occur within two years and be sufficient to deter or counteract the anticompetitive effects of the proposed merger.[49] Entry barriers to the health insurance industry may include: state laws and regulations, economies of scale, and firm reputation.

According to an ongoing study of health care markets in 12 geographic areas, the studied markets fall into three categories: (1) locales with a dominant Blue Cross plan, (2) locales with three or four major plans, typically one of which is a long-standing local plan, and (3) markets that are more fragmented, often lacking strong local plans. According to this study, in recent years national plans have been unsuccessful entering some of the Blue Cross dominant markets, but have been important players in some of the fragmented markets.[50]

The cost of establishing a network of providers may delay entry, depending on the type of insurance product. For example, in *Aetna* the Division alleged that "[e]ffective entry – entry and growth to minimum viable scale – for an HMO or HMO-POS plan in either Houston or Dallas typically takes two to three years and costs up to $50 million."[51] Several panelists agreed that entry barriers into health insurance markets appear to exist. One panelist presented research data suggesting that the health insurance industry has become less competitive over the last few years.[52] This panelist pointed out that recent premium increases usually would have spurred

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[48] Stephen Foreman & Dennis Olmstead, *Written Comments of the Pennsylvania Medical Society* 3 (9/9/02), *at* http://www.ftc.gov/ogc/healthcare/pms.pdf. *See also* Gabel 4/23 at 159 (in last few years, "the insurance industry has become less competitive"); Foreman 4/24 at 69-70; Hall 4/25 at 74-75, 78 (stating that Blue Cross is dominant in Alabama).

[49] MERGER GUIDELINES, *supra* note 1, § 3.

[50] Ginsburg 4/23 at 10-12; Paul Ginsburg, *Competition in Health Insurance* 6-7 (4/23) (slides) (noting that the underwriting cycle was leading to wider margins but that "exits from unprofitable markets" continued) [hereinafter Ginsburg Presentation], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/030423ginsburg.pdf.

[51] *Aetna Complaint*, *supra* note 26, ¶ 23. *See also Aetna Impact Statement*, *supra* note 26, at 8 n.4 ("Indeed, Aetna has acknowledged that on average it costs between $600 and $1000 per enrollee to build membership in a HMO."); *Aetna Complaint*, *supra* note 26, ¶ 23 (further noting that these costs are substantially higher than those required for setting up a PPO or indemnity plan).

On the other hand, the Division also noted in Congressional testimony that "there has been new entry into various local [health plan] markets" and that "[b]etween 1994 and 1997 over 150 new HMOs were licensed across the country." *Statement: Hearing on H.R. 1304, The Quality Health-Care Coalition Act of 1999, Before the House Comm. on the Judiciary*, 106th Cong. 8 (1999) (Statement of Joel I. Klein, Assistant Attorney General, Department of Justice Antitrust Division), *available at* http://www.usdoj.gov/atr/public/testimony/2502.pdf.

[52] Gabel 4/23 at 159.

increased HMO entry.[53] HMO entry is not occurring in most markets, however, because many insurers and HMOs were hurt during fierce price competition in the mid-1990's, Wall Street is wary of HMOs with aggressive entry strategies, and the cost of entry is greater now than in previous periods.[54]

Other panelists acknowledged that, at least in some cases, state laws and regulations can create entry barriers.[55] One panelist stated that the need to create a provider panel is usually not a significant barrier to market entry because existing, commercially-attractive provider networks may be rented.[56]

A former insurance commissioner for Missouri discussed several HMO mergers that his office reviewed during his tenure.[57] His office approved three of the four mergers because they were persuaded by the parties' arguments that entry was easy, that there were no capacity constraints on existing competitors (there were at least ten HMO competitors), and that any of the 320 insurers in the state could easily enter the HMO market.[58] Over the past eight years, however, the St. Louis HMO market has become very concentrated, and there has been no entry since the mid-1990s, he reported.[59]

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[53] Gabel 4/23 at 163-64; Jon Gabel, *Competition Among Health Plans* 11 (4/23) (slides) [hereinafter Gabel Presentation], *at* http://www.ftc.gov/opp/hc/030423jongabel.pdf (suggesting that entry should have begun to increase for at least three reasons: (1) four years of underwriting profits, (2) growing profitability among publicly traded managed care companies, and (3) a limited number of competitors in many local markets). *See also* Ginsburg 4/23 at 20 (noting that "during the stage of the underwriting cycle when premium trends are exceeding cost trends, you expect to see exits from markets rather than entry, and from our on-the-ground sense at 12 sites, we are still seeing some exits, we're not seeing any entry"); Ginsburg Presentation, *supra* note 50, at 13.

[54] Gabel 4/23 at 168-69; Gabel Presentation, *supra* note 53, at 15.

[55] *See, e.g.*, Desmarais 4/23 at 33, 35 (suggesting that in order "[t]o understand the current insurance marketplace, it's important to recognize that insurers are subject to intense government scrutiny of their business practices" and that state policies sometimes reduce the number of insurers willing to do business in a particular state); Stephen Foreman, *Competition Among Health Plans* 11 (4/24) [hereinafter Foreman (stmt)], *at* http://www.ftc.gov/opp/hc/030423forman.pdf (noting that entry barriers include costs of regulatory approval, including capitalization). See also, Senkewicz 4/24 at 8-17 (outlining state regulatory procedures for insurers, but noting that state regulators do not view the requirements as barriers, but as good, sound regulation of an industry where the transactions are not at arms-length).

[56] *See* Lerner 4/23 at 106-107 (suggesting employer community could set up own HMO if monopolist managed care plan unreasonably raised rates, absent the monopolist "tying up the provider community with exclusive contracts or something"); Wu 4/23 at 118-19. *But see* Foreman (stmt), *supra* note 55, at 9.

[57] Angoff 4/24 at 39-45.

[58] *Id. See also* American Bar Ass'n, *Comments Regarding the Federal Trade Commission's Workshop on Health Care and Competition Law and Policy* 8-9 (Public Comment).

[59] Angoff 4/24 at 43-45.

This panelist suggested that entrants face a Catch 22 – they need a large provider network to attract customers, but they also need a large number of customers to obtain sufficient price discounts from providers to be competitive with the incumbents. Second, he noted the possibility that there is a first mover, or early mover, advantage in the HMO industry, possibly resulting in later entrants having a worse risk pool from which to recruit members. Third, he noted that trade name recognition may inhibit entry.[60]

Other panelists agreed that the need for scale economies and a good reputation in the local market may create entry barriers. For example, historically, HMOs' scale economies were relatively low, requiring approximately 65,000 enrollees.[61] Recent information from investigations and the Hearings suggest this may no longer be the case.[62] One panelist noted that it is not uncommon for employers to ask for new or improved quality control and disease management programs from health plans seeking their business. Such programs often cost more and require larger patient populations than such programs did in the past.[63]

Moreover, some purchasers want to deal with firms that are already in the particular geographic market even if a firm with a national reputation is seeking to enter that market. For example, one panelist stated that in recent years "the only … successful entry of national plans into markets has come from purchasing hospital-owned health plans, and now that the hospital-owned health plans are mostly gone, I would not be surprised if we wouldn't – certainly, in the short term, I wouldn't expect to see much national plan entry."[64]

Conversely, other panelists suggested that expansion by existing firms is relatively easy.

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[60] *Id.* at 46-49. *See also* Foreman (stmt), *supra* note 55, at 7-8 (arguing that "mergers may have the effect of increasing brand name loyalty even though there has been no change in quality"); Angoff 4/24 at 52 (suggesting that perhaps the Guidelines should be revised to state that "even when a merger does not meet the Herfindahl thresholds, in a market, where entry is particularly difficult, and efficiencies are clearly not going to be created," the merger should be challenged). *But see* Lerner 4/24 at 119-20 (noting that the antitrust laws should not be used to challenge inefficient mergers that do not raise competitive concerns).

[61] *See* Ruth S. Given, *Economies Of Scale And Scope As An Explanation Of Merger And Output Diversification Activities In The Health Maintenance Organization Industry*, 15 J. HEALTH ECON. 685 (1996); Douglas Wholey et al., *Scale And Scope Economies Among Health Maintenance Organizations*, 15 J. HEALTH ECON. 657 (1996).

[62] *See, e.g.*, Ginsburg 4/23 at 19 (noting that one of the stated reasons for many of the recent health insurance mergers is "to achieve scale economies which presumably could come from the use of information technology and marketing and the same promotional programs and in-care management and how to do it"); Given 4/24 at 30-31, 33-37 (suggesting that the need for larger economies of scale and efficiencies, resulting in larger HMO size, also may create greater barriers to entry).

[63] *See generally* Ginsburg 4/23 at 18 ("Disease management and case management, these are new areas and some companies are pursing it in a more sophisticated way."); Given 4/24 at 33.

[64] Ginsburg 4/23 at 28-29. *See also* Foreman (stmt), *supra* note 55, at 8 (arguing that "developing credibility with employer-purchasers" is an entry barrier).

One panelist stated entry is easy because existing health plans do not face capacity constraints, the incremental cost of expansion is small, and regulatory requirements are generally minor.[65] This panelist explained that informed and sophisticated employers and consultants help to keep the markets competitive by using competitive bidding to choose a health plan, and switching readily based on price.[66] Moreover, large employers often choose to be self-insured, bypassing traditional insurance plans altogether.[67] This panelist offered the Atlantic City, New Jersey, market as an example of entry creating effective competition.[68] Another panelist stated that "all that is required for a plan already licensed in a state to expand to another area of that state is to contract with an existing provider network and then market their new product."[69]

D. Efficiencies

The *Merger Guidelines* make clear that efficiencies should be evaluated before determining whether a proposed merger is likely to be pro- or anti-competitive.[70] The *Merger Guidelines* provide that the Agencies "will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market."[71] Efficiencies are cognizable when they are merger-specific, have been verified, and do not arise from anticompetitive reductions in output or service.[72]

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[65] Wu 4/23 at 119; Wu Presentation, *supra* note 42, at 5; Wu 4/24 at 53-62 (discussing studies of entry, expansion, and customer switching .between health plans), 62 (concluding that, based on the studies he has reviewed, entry and expansion have been sufficient to take share away from the leading firm and have reduced HMO concentration over time, and that this evidence, along with facts about the percentage of employees who have a choice of plans, suggest that although there are switching costs, they do not rise to the level of being a barrier to entry).

[66] Wu 4/23 at 120-23; Wu Presentation, *supra* note 42, at 6-11; Wu 4/24 at 57-62.

[67] Wu 4/23 at 118.

[68] *Id.* at 123-24; Wu Presentation, *supra* note 42, at 11 (showing that from January 1994 through December 1998, new entrants captured 47 percent of the HMO/POS market from six incumbent firms and that the largest incumbent, Blue Cross & Blue Shield of New Jersey, went from having 38 percent of the market to 21 percent). *But see* Foreman 4/24 at 69 (arguing that more recent data suggests that there are only two insurers left in the Atlantic City, New Jersey market).

[69] *Id.* at 41. *See also Id.* ("In the late 1990s, there were many examples in many states where insurers rapidly expanded services from one part of the state to the next and the data showed that this expansion came at a very low price.").

[70] MERGER GUIDELINES, *supra* note 1, § 4 (as revised Apr. 8, 1997).

[71] *Id*. § 4.

[72] Merger-specific efficiencies are "only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects." *Id*. Cognizable efficiencies are assessed "net of costs produced by the merger or incurred in achieving those efficiencies." *Id.*

A merger may generate efficiencies for the merged HMO or other health plan that reduce the costs of hospitals, physicians, or other providers that deal with it. For example, one panelist discussed how HMOs might achieve economies of scale.[73] She noted that HMOs might lower supply-side costs by negotiating better prices with local physician and hospital networks.[74] Moreover, economies of scale may create lower costs for complying with state regulations, administering the HMO, or implementing disease and utilization management, she noted.[75] She maintained that these real cost savings are akin to a technological innovation that lowers input costs.[76]

Another panelist suggested that because the lower input price reflects genuine cost savings in the supply chain, overall welfare increases.[77] The first panelist discussed demand-side efficiencies (including broader provider networks, more financially stable and better managed organizations, and a larger patient population to provide a critical mass for population health and disease management programs) that may improve or increase the value of the HMO to the customer.[78]

Several panelists discussed the number of enrollees an HMO needs to achieve economies of scale. One panelist stated that HMOs reach maximum efficiencies with between 30,000 and 50,000 enrollees.[79] Another panelist suggested a similar range to have economies of scale, and observed that these efficiencies generally apply up to 115,000 enrollees.[80] A third panelist observed that in very small markets these scale economies may be difficult to achieve, and some markets probably cannot support large numbers of health plans.[81]

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[73] Given 4/24 at 27-34; Ruth Given, *National HMO Trends* 6 (4/24) (slides) [hereinafter Given Presentation], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/0304given.pdf. *See also* Given at 4/24 at 111-12 ("[J]ust because you have economies of scale doesn't mean you have merger-specific efficiencies").

[74] Given 4/24 at 33 (noting that plans may need to be bigger to negotiate with providers who also have gained greater market concentration); Given Presentation, *supra* note 73, at 6.

[75] Given 4/24 at 32-36; Given Presentation, *supra* note 73, at 6.

[76] Given Presentation, *supra* note 73, at 6; Given 4/24 at 32-37; *see also* Schwartz 4/25 at 9.

[77] Schwartz 4/25 at 9. *See also* Given 4/24 at 34-37; Given Presentation, *supra* note 73, at 6.

[78] Given 4/24 at 34-37; Given Presentation, *supra* note 73, at 6.

[79] Given 4/24 at 32 -33 (noting that an article she wrote discussed maximizing efficiencies at about 115,000 enrollees, but in that case she was discussing the "whole state of California, and it's about 30- to 40,000 when you adjust for" the number of geographic markets in which HMOs compete in the state; further noting, however, that these numbers may be biased low for current market conditions).

[80] Gabel 4/23 at 165-66; Gabel Presentation, *supra* note 53, at 9 (summarizing the literature about HMO market structure and performance and noting that local market competition increased between 1994 and 1997 despite national mergers, and that local markets determine the level of competition).

[81] Senkewicz 4/24 at 65-66.

Several panelists suggested that researchers or the Agencies examine whether consummated health insurance mergers realized the efficiencies they claimed premerger.[82] To date, the Division has reviewed very few health insurance mergers where the parties claimed that the merger would result in efficiencies that can reasonably be accomplished only by the proposed merger or other means having comparable anticompetitive effects.

E. Conclusion

The Agencies will continue to follow the *Merger Guidelines* in health insurance mergers and conduct a factually intensive, case-specific assessment of whether a particular transaction under review will allow health plans to exercise market power with regard to their customers.[83]

III. MONOPSONY POWER

Conceptually, monopsony power is the mirror image of monopoly power. A buyer has monopsony power when it can profitably reduce prices in a market below competitive levels by curtailing purchases of the relevant product or services.[84] The exercise of monopsony power causes competitive harm because the monopsonist will reduce purchases of the input, shift some purchases to a less efficient source, supply too little output in the downstream market, or do all three. When a monopsonist reduces purchases of inputs to reduce input prices, society foregoes the production of output whose value to consumers exceeds the resource costs of associated inputs, thereby creating a welfare loss to society.[85] To be sure, a buyer's post-merger ability to

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[82] *See* Foreman 4/24 at 117; Angoff 4/24 at 117-118. *See also id.* at 122; Lerner 4/24 at 120, 123. Both panelists suggested that the Agencies work more closely with state insurance regulators with respect to health plan mergers.

[83] *See, e.g.*, Feldman 4/23 at 96 ("Unfortunately, I think antitrust cases have to be done one at a time"); Lerner 4/23 at 97-98 ("So, I think a lot of these things, I agree, you have to look at the case you're dealing with and figure out what makes sense"); Monk 4/23 at 98 ("[W]hen you're looking at a specific market, you do have to factor in what the characteristics that are in that market at that time and whether the characteristics changed because there was a change in - either the market was currently in balance or out of balance"). *See also* Ginsburg 04/24 at 7 ("The key to performance by health insurers is really the direction that they get from employers, and I think the problems we have now often stem from the type of directions or absence of it that insurers are getting from employers, their customers").

[84] Schwartz 4/25 at 8-9; *see also* Dick 4/25 at 4. When a group of buyers combines to exercise market power it is called oligopsony power.

[85] Schwartz 4/25 at 9-11; Marius Schwartz, Buyer Power Concerns and the *Aetna-Prudential* Merger, Address Before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), *available at* http://www.usdoj.gov/atr/public/speeches/3924.wpd.

lower the cost of inputs is not necessarily an exercise of monopsony power.[86]

The Agencies have brought several cases that challenged the actual or potential exercise of monopsony power.[87] Two relatively recent Division cases, both settled by consent decree, alleged that the mergers would have led to monopsony power in some markets. *United States v. Cargill, Inc.*[88] involved a challenge to a merger of grain purchasers, and *United States v. Aetna, Inc.*[89] involved a challenge to the merger of two health care insurers, Aetna and Prudential.

Monopsony concerns can arise in health insurer mergers,[90] as well as in other contexts, including market allocation agreements among competing purchasers, most favored nation (MFN) clauses, and exclusive or quasi-exclusive dealing contracts.[91] Some of the Agencies' MFN cases can be seen as monopsony-related matters, as they dealt with the power of purchasers of services (such as dental, vision, or hospital care services) to impose contract terms on sellers of those services (such as dentists, optometrists, or hospitals).[92]

A. Product and Geographic Market Definition

As with monopoly analysis, an important aspect of monopsony analysis is market definition. One panelist noted that there are not many monopsony cases that clearly analyze market definition.[93] Buyer-side product market definition, in particular, is an active area of

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[86] Schwartz, *supra* note 85, at 5; *see also* Schwartz 4/25 at 9 ("If, for example, a merger enables the now bigger buyer to get a lower price because of efficiencies, for example, [when] it buys in bulk, and that saves resources, and that's what enables a lower wholesale price, then that's a good thing. That is likely to also increase the amount of the input that's purchased and, therefore, is a good thing for overall economic performance.").

[87] The Division defined monopsony markets in both *Aetna/Prudential* and *Cargill/Continental Grain*. *Aetna Complaint*, *supra* note 26, ¶ 27; *Aetna Impact Statement*, *supra* note 26, at 9; United States v. Cargill, Inc., No. 1:99CV01875 ¶¶ 17-19 (July 8, 1999) (complaint), *available at* http://www.usdoj.gov/atr/cases/f2500/2552.pdf. *See also* Schwartz 4/25 at 8-22. The Commission defined monopsony markets in several cases, including *In re* BP Amoco, PLC, Dkt. No. 3938 (Aug. 25, 2000), complaint at ¶¶ 43-48 (complaint alleged that merger would lessen competition in bidding for rights to explore the Alaska North Slope).

[88] United States v. Cargill, Inc., 2000-2 Trade Cas. (CCH) ¶ 72,966 (D.D.C. 2000).

[89] United States v. Aetna, Inc., 1999-2 Trade Cas. (CCH) ¶ 72,730 (N.D. Tex. 1999).

[90] *See also supra* Chapter 1.

[91] *See* Miles 4/25 at 44.

[92] *See* United States v. Med. Mut. of Ohio, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio 1999); United States v. Delta Dental of R.I., 943 F. Supp. 172 (D.R.I. 1996); United States v. Vision Serv. Plan, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996).

[93] *See* Miles 4/24 at 130-31. This panelist said that the cases that do address monopsony power have not done a good job of analyzing market definition issues, defining the market in terms of the output market rather than the input market. *Id.* He noted, however, that the Second Circuit's decision in Todd v. Exxon, 275 F.3d 191 (2d Cir.

academic and legal inquiry, and is an area in which additional research is desirable.

Defining a buyer-side market involves reversing the standard seller-side formula to ask about the extent to which at-risk suppliers will substitute other outlets for their products or services in response to a small but significant and non-transitory *decrease* in price. The crucial consideration in defining monopsony product and geographic markets, therefore, is whether the buyers of the input in the putative market successfully would be able to lower the price they pay for the input or whether, instead, the sellers have sufficient realistic alternatives to allow them to circumvent the price decrease.

Several additional monopsony market definition-related points are worth noting. First, purchasers of the input need not compete in the output market to be included in the relevant market for the purchase of the input.[94] Thus, it is possible that public payors (*e.g.*, Medicare and Medicaid) and private payors (*e.g.*, health care insurers) do not compete in output markets, but do compete in the market for the purchase of services from health care providers. Thus, purchasers of services might be differentiated in their competitive effectiveness just as sellers are differentiated in some downstream markets.[95]

Second, the same analytical tools used in defining markets to assess seller power can be applied when assessing buyer power.[96] Third, a firm need not have seller-side market power in order to have buyer-side monopsony power.[97] Fourth, while the Division previously treated the product market in *Aetna* as physicians' services, rather than defining separate product markets by physician specialty, monopsony antitrust markets might be appropriately defined in other circumstances for physician specialties, hospitals, or other provider groupings.[98] Finally, as in

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2001), which defined the product market by focusing on the interchangeability, from the perspective of plaintiff-employees, of job opportunities in the oil industry and job opportunities in other industries, handled monopsony market definition in a sound manner. *Id.* at 131-32. He also observed that United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940) and Mandeville Island Farms v. American Crystal Sugar Co., 334 U.S. 219 (1948), both involved monopsony power issues in the form of naked price-fixing agreements among buyers with market power. *Id.* at 127-28.

[94] *See id.* at 134; Schwartz 4/25 at 11-12.

[95] *See* McCarthy 4/24 at 202; Blair 4/24 at 204 (noting that when patients need medical services, "whether they're represented by a commercial health insurer or a government health insurer … [they] contribute to the demand that's placed on the physician's time"); *but see* Foreman 4/24 at 204 (stating that it is a "non-answer" to tell physicians that their "response to a monopsony reduction in prices [should be] to expand your Medicare and Medicaid patient list").

[96] *See* Miles 4/24 at 134.

[97] *See* discussion of *Cargill*, *infra* notes 124-128, and accompanying text.

[98] *Aetna Complaint*, *supra* note 26, ¶ 27; *Aetna Impact Statement*, *supra* note 26, at 9; *see also* McCarthy 4/24 at 166-67 (indicating that physician product market definition, in the context of monopsony, should be "basically specialty-specific").

other areas of antitrust analysis,[99] the presence or absence of price discrimination can, at times, play an important role in monopsony power analysis.[100]

B. Seller Switching Costs

Seller switching costs are an important part of monopsony analysis. Seller switching costs are the costs faced by suppliers (*e.g.*, health care providers) in switching to different outlets (*e.g.*, health care insurers) for their services. High seller switching costs make it more difficult for a provider, when faced with lower reimbursement from a monopsonist health care insurer, to switch business to another health care insurer. Consequently, high seller switching costs make it more likely that monopsonist health care insurers could exercise market power against health care providers. Although such switching costs may vary depending on the specifics of a market, they can be significant for health care providers.[101]

Seller switching costs for physicians can be significant because: (1) a physician's time is perishable and (2) it can be difficult for a physician to quickly replace lost patients.[102] Some have offered other reasons that physician switching costs can be significant. First, some have noted that such switching costs may be greater when a seller has invested in specialized assets and have suggested that the training undergone by physicians may be such an investment.[103] Second, some have noted that seller switching costs can be higher if the sellers are not mobile and have suggested that health care providers may not be geographically mobile.[104]

Other panelists disagreed with the notion that the seller switching costs faced by providers are substantial, and argued that some physicians are both geographically mobile and are able to

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[99] *See, e.g.*, United States v. Dairy Farmers of Am., Inc., No. 6:03-206 (Apr. 24, 2003) (complaint), *available at* http://www.usdoj.gov/atr /cases/f200900/200972.pdf.

[100] There was some disagreement among Hearings participants about the extent of price discrimination that actually occurs with respect to physician services. *Compare* Schwartz 4/25 at 16 (noting that there was a good deal of evidence in *Aetna* that "Aetna and other payors did not set their prices to physicians uniformly on a market wide basis, but rather, negotiated prices separately with individual physicians or individual physician groups"), *with* Frech 4/24 at 221 (stating that, once one looks past large physician groups, health care insurers do not engage in much price discrimination with respect to physicians).

[101] *See* Foreman 4/24 at 175-77.

[102] *See* Schwartz 4/25 at 17; Foreman 4/24 at 175-77. This panelist added that the different billing, quality assurance, and other systems that insurers use can make it difficult for physicians to switch to serving patients covered by another health care insurer. *Id.* at 176-77.

[103] *See* Foreman 4/24 at 175-76; Frech 4/24 at 190.

[104] *See* Foreman 4/24 at 175-76. A related question to the issue of physician mobility is how quickly must provider migration remedy a monopsony situation to make an antitrust remedy inappropriate. *See* Frech 4/24 at 190.

serve other health care insurers locally.[105] These panelists also suggested that physicians facing a monopsonist may be able to respond by filling their practices with cash paying patients, closing their practices (*i.e.*, not taking on new patients from a health care insurer), or encouraging existing patients enrolled in the monopsonist health care insurer to change to other health care insurers.[106] The Agencies believe these competing claims are fact-specific empirical propositions that can only be resolved in the context of a particular matter.

C. Competitive Effects

1. Insurer Market Share and the Cost of Provider Withdrawal

Two recognized analyses of market share in the context of health care insurer monopsony are: (1) the health care insurer's locality-wide share, which is the health care insurer's market share of patients or patient dollars in a local market and (2) the health care insurer's share of each physician's business.[107] The locality-wide share indicates the size of the pool of patients available to the provider, if that provider were no longer to treat the monopsonist health care insurer's patients.[108]

The share of each provider's business, which matters only because there are switching costs, shows the number of patients a provider would have to replace, if the provider were no longer to treat the health care insurer's patients.[109] If either type of market share is high, a provider faces high per-patient replacement costs if the provider no longer treats the health care insurer's patients.[110] If both market shares are high (and other factors are present) then a health care insurer merger or health care insurer monopsony conduct could allow the insurer to impose significant price reductions on a nontrivial number of providers.[111]

It is difficult, in the abstract, to state market share thresholds for such monopsony concerns. In part, this is because determining the existence of monopsony power requires the Agencies and courts to look at other factors in addition to the health care insurer's market share. The classic elements of monopsony power have been described as: (1) a large market share on the part of the purchaser; (2) an upward sloping or somewhat inelastic supply curve in the input market; and (3) an inability or unwillingness for new purchasers to enter the market or current

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[105] *See* McCarthy 4/24 at 163-64, 189.

[106] *See id.* at 213-214; McCarthy 4/25 at 135; Miles 4/24 at 213.

[107] *See* Schwartz 4/25 at 17-19.

[108] *See id.* at 18.

[109] *See id.* at 19.

[110] *See id.* at 18-20.

[111] *See id.* at 21-22.

purchasers to expand the amount of their purchases in the market.[112]

2. Distinguishing Lawful From Unlawful Behavior

Of course, even if a health care insurer has monopsony power, the issue for antitrust purposes is whether the health care insurer has obtained or maintained that power through improper means.[113] If reimbursement levels are low due to lawfully obtained and exercised health care insurer market power, then there is no antitrust violation.

One area of health care insurer activity that may sometimes be confused with unlawful monopsony behavior is lawful managed care contracting. Managed care plans and other health care insurers can legitimately lower health care provider prices by increasing competition among health care providers or engaging in other activities that lower the costs of provider services. Indeed, because one of the purposes of managed care is to lower prices closer to a competitive level, it can be difficult to determine when a managed care purchaser is exercising monopsony power.[114]

The First Circuit dealt with this issue in *Kartell v. Blue Shield of Massachusetts*.[115] In *Kartell*, physicians sued Blue Shield, alleging that its prohibition on "balance billing" was an unreasonable restraint of trade or an act of monopolization or attempted monopolization.[116] The First Circuit, in rejecting this antitrust challenge, assumed for purposes of its analysis that Blue Shield had market power and that it used the market "power to obtain 'lower than competitive' prices."[117] The court said that as long as the prices were not predatory, or below anyone's

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[112] *See* Miles 4/25 at 35-36. Some disagree on whether the physician supply curve is upward sloping or inelastic in many markets. *Compare* McCarthy 4/24 at 217 (indicating that the physician supply curve may be flat in many areas due to excess capacity), *with* Foreman 4/24 at 218 (stating that there is not "evidence of excess supply" and "depending on the specialty … [there are] some intermediate term concerns about supply.").

[113] *See* Miles 4/25 at 43-44.

[114] *See* Frech 4/25 at 24-25. *See also id.* at 24-25 (noting that HMOs and PPOs can "improve competition and lower prices" because they "perform search[es] for consumers and they provide stronger incentives for choice of the low-priced sellers"), 28 (also noting that "reducing prices towards the competitive level is one of the general purposes of managed care and … – to the extent it happens – one of the competitive benefits of managed care and efficient health plans").

[115] 749 F.2d 922 (1st Cir. 1984).

[116] *Id.* at 923. Balance billing refers to the practice whereby a provider bills patients for the difference between what the insurer pays to the provider and the provider's billed charge for the service. The prohibition on balance billing prohibits the provider from collecting money, other than copayments or deductibles, directly from the patient and requires providers who sign a participating provider agreement with Blue Shield "to accept as payment in full an amount determined by Blue Shield's 'usual and customary charge' method of compensation." *Id.*

[117] *Id.* at 927.

incremental cost, "a legitimate buyer is entitled to use its market power to keep prices down."[118]

One way to distinguish monopsony conduct from other market situations is to look for indicia of such conduct.[119] One panelist suggested possible indicia including: (1) a decline in market output; (2) a pattern of provider exit because of low rates; (3) a large share of total market-wide reimbursements from the alleged monopsonist; (4) single rates for specialties rather than contract negotiations; (5) low reimbursement levels to providers; (6) limited opportunities to treat noncommercial patients; (7) low incomes for physicians and low profit margins for efficient providers; (8) no systematic excess capacity by providers market-wide; (9) few rival health care insurers; (10) low rates paid by rival health care insurers; and (11) difficulty of entry into the health care insurance market.[120] It is important to note that these indicia are not, individually or collectively, items that must be proven to show monopsony conduct.

3. Lowering Prices Below the Competitive Level

Some have said that the Agencies should be concerned whenever a transaction or practice leads to a lowering of prices.[121] A more appropriate way of framing this issue is that the Agencies should be concerned only if the transaction or practice leads to prices below competitive levels. Of course, this requires a determination of the "competitive pricing level," which is a daunting task.[122] Health care prices can be defined in a number of different ways, and even with an agreed-upon benchmark for competitive reimbursement, it can be difficult to know whether the price paid to health care providers has changed.[123]

4. Monopsony Power Absent Downstream Market Power

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[118] *Id.* at 927-28, 929. The court also cited to three additional circumstances that argued "against any effort by an antitrust court to supervise the Blue Shield/physician price bargain …. First, the prices at issue are low prices, not high prices …. Second, the subject matter of the present agreement – medical costs – is an area of great complexity where more than solely economic values are at stake …. Third, the price system here at issue is one supervised by state regulators." *Id.* at 930-31.

[119] *See* Brewbaker 9/26 at 50-53 (listing variety of factors indicating that payors lack monopsony power). *See also* Timothy J. Muris, Everything Old is New Again: Health Care and Competition in the 21st Century, Speech Before the 7th Annual Competition in Health Care Forum 16-18 (Nov. 7, 2002), *available at* http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf (noting that physicians who entered into consent agreements to settle FTC allegations of anticompetitive conduct were not located in areas with high payor concentration – indicating that the driving force behind such conduct was not an attempt to offset monopsony power).

[120] *See* McCarthy 4/25 at 65-69. *See also* discussion of entry, *supra* notes 49-69, and accompanying text.

[121] *See* Foreman 4/25 at 122-23.

[122] *See* Frech at 25. *See also Kartell*, 749 F.2d at 927-28 (noting the difficulty of determining what is a reasonable or competitive price) and *infra* Chapter 7 (discussing the difficulties of using price controls to reflect competitive prices).

[123] *See* Frech 4/25 at 25-27.

Finally, it should be noted that payors need not have monopoly power in downstream markets to have monopsony power in upstream markets.[124] Thus, in cases such as *Cargill*, a monopsony may affect suppliers but not consumers.[125] In *Cargill*, the Division challenged a merger that would have created a monopsony purchaser of grain in some local markets.[126] The merging companies, however, sold grain in world markets, in which they faced competition from many other grain sellers.[127] Thus, even if the merged firms imposed a loss on farmers by cutting back the quantity of grain they bought from them, consumers of the merging companies would not be harmed because they had numerous other sources of supply.[128] The harm in the upstream market, however, was sufficient to prompt the Division to challenge the merger.

D. Conclusion

The Hearings confirmed two important, interrelated points with respect to monopsony power in the health insurance sector. First, under the right circumstances, monopsony power can be created or exercised in this industry. The Agencies consequently need to remain vigilant in monitoring the market for such situations. Second, properly ascertaining whether monopsony power has in fact been created or exercised in this industry typically will involve a case-specific, factually-intense assessment. As panelists pointed out, "'low prices' by themselves are not an indication or certainly not proof of monopsony power,"[129] and correctly determining the presence of monopsony power is "tricky."[130]

IV. CURRENT CONTROVERSIES

A. Most Favored Nation Clauses

An MFN clause is a contractual agreement between a supplier and a customer that requires the supplier to sell to the customer on pricing terms at least as favorable as the pricing terms on which that supplier sells to any other customer. In health care markets, large insurance plans impose these contractual agreements in contracts with hospitals, physicians, and other health care providers. MFNs are sometimes also referred to as "most favored customer clauses," "prudent buyer clauses," or "nondiscrimination clauses."

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[124] *See* Schwartz 4/25 at 11-12; Frech 4/25 at 29-30.

[125] *See* Schwartz 4/25 at 11-12.

[126] *See id.*

[127] *See id.*

[128] *See id.* at 12.

[129] Miles 4/25 at 35.

[130] Frech 4/24 at 31-32.

According to panelists at the Hearings, MFNs may be anticompetitive or procompetitive, depending on the circumstances.[131] Proponents of MFNs argue that they allow an insurer to be confident that the reimbursement it pays a provider is no greater than the rates paid by the insurer's competitors. In certain situations, however, an MFN clause may harm competition either by substantially raising the costs of the insurer's rivals, or reducing provider discounting in the particular market.[132]

Under either theory, any savings in provider costs to the firm imposing the MFN must be weighed against any higher provider costs incurred by that firm's rivals.[133] The Agencies consider economic justifications for MFNs when weighing their potential competitive effects.

According to some panelists, justifications for MFN clauses in other industries are not applicable when applied to the health care industry.[134] For example, MFNs can facilitate long-term contracts in industries such as natural gas, where it is difficult to predict future price changes and industry conditions. They also can be used as a substitute "low-cost seller" signal in industries in which it is difficult and costly for consumers to search for price information.[135]

These justifications for MFNs likely are not applicable to the use of MFNs in health care markets. The "equitable" argument in favor of MFNs that the largest buyer in the market is entitled to a quantity discount and to the best price is not supported by antitrust economics, but it is likely to be advanced by large buyers. In any case, there is no need for a counterintuitive blanket rule against MFNs. There may be situations, however, where an MFN has an anticompetitive effect and as noted above, in any investigation, the agencies would weigh the cost savings to the largest buyer against higher costs that may be incurred by that firm's rivals.[136]

1. Prior Cases

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[131] Overstreet 5/7 at 146 (noting that "[t]here's a fair consensus among economists that have looked at these things that they can be pro-competitive or anticompetitive depending on the factual circumstances"); Kopit 5/7 at 126, 132-35; Baker 5/7 at 139-43; Snow 5/7 at 154-55.

[132] As discussed *infra* notes 148-?, and accompanying text, MFNs are typically used to eliminate provider discounting if the insurer is controlled by providers.

[133] *See* Kopit 5/7 at 135-38 (suggesting that MFNs imposed by insurers with market power are likely anticompetitive unless they can be shown to reduce cost, similar to the the Robinson-Patman Act's requirement that volume discounts be cost-justified). *See also* Overstreet 5/7 at 148, 190-92 (noting importance of determining actual impact of MFN in weighing theoretical claims that lower costs to the firm imposing the MFN are offset by higher costs to competing firms).

[134] Baker 5/7 at 141-43.

[135] *See id.* at 142-43.

[136] *See generally* Snow 5/7 at 156-57 (arguing "that in most cases, the largest buyer is entitled to a quantity discount and to the best price"). *See also* discussion *infra* note 153; Kopit 5/7 at 136-37 (suggesting some providers may have the incentive to offer smaller insurers lower rates in order to fill their remaining beds).

The Agencies have brought several cases involving MFNs.[137] Only a few of those cases have resulted in judicial opinions, and they provide little guidance other than that MFNs are not per se lawful.[138] *Delta Dental Of Arizona* and *RxCare* involved provider-controlled insurers that imposed an MFN in order to eliminate provider discounting. *Vision Service Plan* and *Medical Mutual Of Ohio* involved insurers that were not provider-controlled and used their monopsony power to raise their rivals' costs. In *Delta Dental of Rhode Island* the federal district court issued an opinion that held that MFNs are not per se lawful.[139]

Private litigation has had mixed results. In both *Ocean State* and *Kitsap v. Washington Dental,* courts found that the MFN clauses at issue did not violate the antitrust laws.[140] In *Ocean State*, the First Circuit concluded, as a matter of law, that a prudent buyer policy, essentially identical to the MFN clauses in other antitrust cases, did not constitute monopolization in violation of Section 2 of the Sherman Act.[141] In *Marshfield Clinic*, the Seventh Circuit stated that the suggestion that the MFN established a price-floor for physicians' prices is an "ingenious but perverse argument."[142] The court acknowledged that an MFN might be misused to anticompetitive ends, but concluded there was no evidence of such conduct in that case.[143]

Other courts have recognized the anticompetitive potential of MFN clauses. In *United States v. Eli Lilly*, the court found that the MFN clause explained the existence of prices higher

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[137] United States v. Delta Dental Plan of Ariz., 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995); United States v. Or. Dental Ser. 1995-2 Trade Cas. (CCH) ¶ 71,062 (N.D.Cal. 1995); United States v. Vision Serv. Plan, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996); United States v. Delta Dental of R.I., 943 F. Supp. 172 (D.R.I. 1996); United States v. Med. Mut. of Ohio, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio 1999); *In re* RxCare of Tenn., Inc., 121 F.T.C. 762 (1996).

[138] *e.g.*, Baker 5/7 at 143-45.

[139] *Delta Dental of R.I.*, 943 F. Supp. at 176. In a case involving enforcement of an administrative subpoena, the 6th Circuit made a similar observation. Blue Cross & Blue Shield of Ohio v. Klein, 117 F.3d 1420 (6th Cir. 1997) (unpublished opinion). *See also* Kopit 5/7 at 127-31; Overstreet 5/7 at 153.

[140] Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989); Kitsap Physician Serv. v. Wash. Dental Serv., 671 F. Supp. 1267 (W.D. Wash. 1987). For a discussion of *Ocean State*, see Kopit 5/7 at 124-27, 129-30, 134-35 and Snow 5/7 at 154-57.

[141] *Ocean State*, 883 F.2d 1101 (1989). *See also* Kopit 5/7 at 125-27. *But see* Independence Blue Cross, *July 23, 2003, Letter re: FTC/DOJ Hearings on Health Care and Competition Law and Policy* 1 (Public Comment) (arguing that Independence Blue Cross's "Prudent Buyer" clause is not an MFN clause).

[142] *Marshfield Clinic*, 65 F.3d at 1415.

[143] *Id. See also* Baker 5/7/03 at 144; Jonathan Baker, *Competitive Effects of Most Favored Nation Clauses in Health Care Markets* 12 (5/7) (slides) [hereinafter Baker Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507baker.pdf; Kopit 5/7 at 119-21 ("One of the interesting things about that is there was no MFN in the case …. So, to say it was gratuitous, I'd say that's a fair statement.").

than the competitive price, although there was no evidence of conspiracy.[144] In *Reazin v. Blue Cross & Blue Shield*, the court found that the MFN provided evidence of Blue Cross's market power, and the Tenth Circuit explicitly stated that the *Ocean State* decision did not alter its conclusion with respect to Blue Cross's possession of monopoly power.[145] Several other cases also have discussed the anticompetitive potential of MFN clauses.[146]

2. Competitive Concerns

MFNs, as used in health care markets, may result in competitive harm based upon two different theories.[147] First, MFNs can facilitate coordination among health care providers in certain instances where the insurer imposing the MFN is provider-controlled.[148] Under these circumstances, the MFN can make cheating on a cartel price more transparent and provide an enforcement mechanism that can be used against a price-cutting provider.[149]

For example, according to the allegations in *RxCare*, the Tennessee Pharmacists Association organized most of the pharmacies in Tennessee into a single provider network that used an MFN clause to discourage discounting and effectively create a price floor. One of RxCare's stated goals was to "define and promote appropriate compensation to pharmacists for patient care."[150] The Commission's complaint alleged that RxCare and the association used the MFN clause to restrain "rivalry in the provision of pharmacy benefit prescription services among Tennessee pharmacies … [and harm] consumers by limiting price competition and entry into pharmacy network services."[151]

Second, insurers that are not controlled by providers may impose MFNs to deter hospitals or other providers from granting discounts to competing health insurers. Under this theory, the

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[144] United States v. Eli Lilly, 24 F.R.D. 285 (D.N.J. 1959).

[145] Reazin v. Blue Cross & Blue Shield of Kan., Inc., 899 F.2d 951, 971 n.30 (10th Cir. 1990). The Tenth Circuit noted that it did not need to reach the question addressed in *Ocean State* of whether an MFN clause could itself violate Section 2. *Id.* at 971 n.30.

[146] Williamette Dental Group v. Oregon Dental Serv. Corp., 882 P.2d 637 (Or. App. 1994); *In re* Brand Name Prescription Drugs, 288 F. 3d 1028, 1033 (7th Cir. 2002); Baker 5/7 at 141-45; Baker Presentation, *supra* note 143, at 8-12.

[147] *See, e.g.*, Baker 5/7 at 139-40.

[148] *See* Baker 5/7 at 139-40; Overstreet 5/7 at 146-47

[149] *See* United States v. Delta Dental Plan of Ariz., 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995); United States v. Oregon Dental Serv., 1995-2 Trade Cas. (CCH) ¶ 71,062 (N.D.Cal. 1995); *In re* RxCare of Tenn., Inc., 121 F.T.C. 762 (1996).

[150] 121 F.T.C. at 763 ¶ 2 (complaint).

[151] *Id.* at 764 ¶ 8.

MFN may create a barrier to entry or expansion by the insurer's rivals or may raise its rivals' costs, thereby making them less effective competitors.[152] Some panelists noted that providers have less incentive than they otherwise would to accept lower prices from another health plan because they will have to give the lower price to the dominant plan with which they have the MFN agreement. Absent the MFN, panelists noted, some health insurers may offer new or different products, such as more restricted provider panels or tiered co-payments. These alternative insurers may have a greater ability to bargain for lower prices because, unlike many plans, they may have more flexibility in excluding providers or creating incentives for patients to choose low cost providers, panelists explained. Providers may favor the creation of these plans because, panelists observed, they may expand the size of the insured population by making insurance options available to people who otherwise could not afford them.[153]

Under this theory, the inability of the incumbent health plan's rivals to obtain discounts may result in the outright exclusion of rival health plans or new entrants into the market and allow the incumbent health plan to maintain or achieve prices above the competitive level.[154] In *Reazin v. Blue Cross & Blue Shield*, for instance, the court noted there was testimony that alternative delivery systems, such as HMOs, "were the first real challenge to our traditional system of delivering financing of care … [and] that Blue Cross's most favored nations clause hindered the development of alternative delivery systems, thereby interfering with the introduction of competition."[155] The Tenth Circuit observed that, at least in the Kansas market, there were significant barriers to entry and Blue Cross's actions were designed to maintain those barriers.[156]

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[152] Baker 5/7 at 140; Overstreet 5/7 at 147-48.

[153] Hospitals, in order to fill their beds, may compete with each other at the margin for the additional patients that smaller insurers can provide them. A hospital, similar to an airline seeking to fill the seats on a flight, may be willing to serve those few additional patients at rates closer to its marginal cost than it would the bulk of its business. Kopit 5/7 at 136-37. The airline analogy may not capture the full implications of this competition among hospitals over incremental sales, however, because passengers on an airplane do not compete with each other in a downstream market, whereas insurers compete with each other in the sale of health care insurance. The disparity in hospital rates among competing plans may affect that competition to a significant degree. *See* Snow 5/7 at 156-57.

[154] Baker 5/7 at 140; Baker Presentation, *supra* note 143, at 6.

[155] 899 F.2d 951, 970 (10th Cir. 1990). For example, Blue Cross had terminated its contract with one hospital that was participating in an HMO. Moreover, it sent a letter to all other hospitals in its service area warning that if they decided to pursue vertical integration arrangements with insurers, Blue Cross would be forced to reassess its relationship with the hospital, and "[h]ospitals that wish to continue their current relationship with Blue Cross and Blue Shield, that do not seek to enroll subscribers in other programs, and that wish to cooperate with Blue Cross and Blue Shield as a major marketing arm of the hospital, will experience no change in the contractual relationship that has historically served Kansans well." *Id.* at 959 n.8.

[156] *Id.* at 972 & n.32 (rejecting Blue Cross's attempt to rely on *Ball Memorial Hosp. Inc. v. Mutual Hospital Insurance*, 784 F.2d 1325 (7th Cir. 1986), for the proposition that entry barriers in the health care financing market were always low). The 10th Circuit noted that entry barriers might be low in Indiana, where Blue Cross only had 27 percent of the market and there were 500 insurers currently doing business in the state, but they were not low in Kansas.

Interestingly, the plaintiff hospitals in *Ball Memorial* were attempting to prevent Blue Cross from entering

Under either of these theories, market power is an important part of the analysis. Panelists noted that there is no absolute market share threshold above which a firm may be able to employ an MFN anticompetitively.[157] Indeed, the relevant source of market power (and thus the relevant market share inquiry) depends on whether the theory of harm focuses on seller-side or buyer-side imposition of the MFN. For example, where the theory of harm focuses on the first theory (facilitation of provider coordination), the collective market power of the participating providers is an important consideration.

Conversely, where the theory of harm focuses on the second theory (raising rivals' costs or abuse of health insurer monopsony power), the insurer's market power upstream is a relevant inquiry.[158] Indeed, most of the cases finding MFN clauses anticompetitive involved plans with a dominant market share requiring providers to agree to an MFN clause or a dominant provider network requiring providers it contracts with to agree to the MFN clause.[159] Panelists stated that, if the entity requiring the MFN clause has market power, it is more likely that the MFN clause will have anticompetitive effects.[160]

According to one panelist, MFN clauses may facilitate coordination among providers, and dampen competition. Coordination is facilitated because providers have less incentive to cheat on a price agreement by accepting lower prices from another health plan because they will have to give the lower price to the dominant plan with which they have the MFN agreement. Moreover, rival health plans may have less incentive to bargain with providers, because they know they cannot obtain a competitive advantage.[161]

Conclusion. The Agencies will continue to challenge the use of MFN clauses when the evidence suggests that such terms violate antitrust law.

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the market with a PPO product that competed with many of their own. 784 F.2d at 1339. In *Reazin*, Blue Cross was attempting to prevent the hospitals from participating in alternative delivery systems like HMOs and PPOs that might compete with Blue Cross's traditional indemnity plans. 899 F.2d at 964-65.

[157] *See* Kopit 5/7 at 132-33, 194-95; Overstreet 5/7 at 147-48.

[158] *See* Kopit 5/7 at 132-3; Overstreet 5/7 at 147-48.

[159] *See, e.g.*, *RxCare of Tenn.*, 121 F.T.C. 762 (1996); *Reazin*, 899 F.2d at 971 n.30 ("[T]he most favored nation clause here is not itself challenged as unlawful monopolization. Rather, it is only considered as evidence of, or as contributing to, Blue Cross' market or monopoly power"). *See also* Baker 5/7 at 139 (noting that the cases in which MFNs receive antitrust scrutiny usually involve a dominant health plan); Kopit 5/7 at 131.

[160] *See* Overstreet 5/7 at 147 (noting that the "concern in the upstream market is most likely to be a competitive one when that market is concentrated, is subject to oligopoly coordination; in the downstream market, the concern is most likely to be a real issue when the firm imposing the MFN has a large share of the market"); Baker 5/7 at 139-140. *But see* Snow 5/7 at 156 (arguing that an MFN is "primarily a device to prevent price discrimination. . . .[and] that in most cases, the largest buyer is entitled to a quantity discount and to the best price").

[161] Baker 5/7 at 139-41; Baker Presentation, *supra* note 143, at 5. *See also RxCare of Tenn.*, 121 F.T.C. 762.

B. Mandated Benefits

1. Claimed Benefits of Mandates

Proponents view mandates as a way of providing access to benefits valued by beneficiaries but withheld by employers or insurers. Proponents see health care as a "merit good," "the provision of which should not be limited to those who are able to pay for medical care and who see the wisdom in doing so."[162] Proponents also argue that mandates correct for insurance market failures, and that the required inclusion of some benefits in all health insurance plans can be welfare enhancing.[163]

More concretely, one commentator has suggested that plans have an incentive to offer inefficiently inadequate benefits because health insurance contracts are, by necessity, incompletely specified, and mandates prevent post-contractual opportunism and the exploitation of informational asymmetries.[164] The same commentator stated that mandates may also help compensate for the bounded rationality of consumers in choosing among health insurance plans.[165]

Commentators have also suggested that mandates can help solve the problem of adverse selection.[166] According to these commentators, if employees have more information about whether they will face high medical bills than employers do, employers that provide generous fringe benefits may end up attracting employees who are disproportionately likely to make expensive claims. This dynamic might discourage employers from offering comprehensive benefits to employees.

Two panelists noted that many insurers and employers might be reluctant to offer a benefit

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[162] Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 8 (1999). *See also* Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177, 178 (May 1989).

[163] Korobkin, *supra* note 162, at 87-88.

[164] *Id*.

[165] *Id. See also* Summers, *supra* note 162, at 178 (suggesting that individuals may "irrationally underestimate the probability of catastrophic health expenses, or of a child's illness that would require a sustained leave"); Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS. 169, 173 (Fall 2002) ("[T]he complexity of the contract may make it very costly for the ordinary consumer to make comparisons among the few alternative plans most consumers have.").

In such situations, consumers are likely to adopt choice strategies that have various weaknesses. Herbert A. Simon, *Rational Choice and the Structure of the Environment*, 63 PSYCHOL. REV. 129 (1956); James G. March, *Bounded Rationality, Ambiguity, and the Engineering of Choice*, 9 BELL J. ECON. 587, 590 (1978). For example, the greater the number of plan attributes that must be compared and weighed, the more likely it is that consumers will simply focus on the price of the plan. Korobkin, *supra* note 162, at 88.

[166] *See* Gitterman 6/25 at 19; Hyman 6/25 at 85. *See also* Summers, *supra* note 162, at 179.

that attracts high cost employees or beneficiaries.[167] By requiring all insurance plans to cover certain costly illnesses, the risk is spread across a large number of employers/health insurers. Finally, one panelist asserted that mandates may be necessary to prevent discrimination against particular conditions.[168] In this view, mandates ensure parity of access to treatment.[169]

Proponents of mandates generally argue that the costs of an individual proposed mandate are low. For example, one panelist stated that mental health parity laws would, on average, result in premium increases of less than one percent.[170] Proponents of mandates also suggest that any analysis of the cost of the mandated benefit must consider the consequences of failing to provide the mandated coverage.[171]

2. Claimed Disadvantages/ Inefficiencies of Mandates

Opponents of mandated benefits argue that forced inclusion of insurance benefits raises premium costs, and may lead employers to opt out of providing health insurance and employees to drop their coverage.[172] Opponents generally argue that the market is likely to do a more efficient job allocating resources between health insurance and other consumer goods than the

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[167] Hyman 6/25 at 85; Greenberg 9/9/02 at 179-180 (noting risk selection problems in the health care market). *Cf*. Herzlinger 5/27 at 92 (suggesting that providers who treat sicker patients should receive higher payments).

[168] Ibson 6/25 at 19 (noting employers often single out "mental health disorders and impose restrictive limits on care").

[169] *See id.* at 22-24.

[170] *See id.* at 23 (referring to studies performed by PricewaterhouseCoopers and the National Advisory Mental Health Council). *But see* Knettel 6/25 at 78-79 (arguing that flexible interpretations of parity laws and carve out arrangements have made impact of parity requirements "tolerable").

[171] Ibson 6/25 at 24 (arguing that untreated depression costs the economy $44 billion per year in lost productivity); Laser 6/25 at 47-48 (noting that "there was no cost increase due to contraceptive coverage … and the savings of contraceptive coverage outweigh the costs" including savings from "fewer pregnancies, fewer deliveries, and healthier newborns").

[172] *See* Kanwit 6/25 at 37-39; Gitterman 6/25 at 8 ("[W]hy mandate Cadillac coverage when purchasers just want a Chevy."); MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS AND ECONOMICS OF RATIONING MECHANISMS 22, 24 (1997) (identifying mandates as an important source of inefficiency, and observing that "[e]conomists explain that it usually makes no sense to mandate or encourage insurance that many consumers are unwilling to buy.").

Studies suggest twenty to twenty-five percent of uninsured Americans lack coverage because of benefit mandates. GAIL JENSEN & MICHAEL MORRISEY, MANDATED BENEFIT LAWS AND EMPLOYER-SPONSORED HEALTH INSURANCE 1 (1999) (prepared for Health Insurance Ass'n of America), *available at* http://www.insureusa.org/research/ jensen.htm; Frank A. Sloan & Christopher J. Conover, *Effects of State Reforms on Health Insurance Coverage of Adults*, 35 INQUIRY 280 (1998). *See also* Kanwit 6/25 at 38-39; T. Miller 6/25 at 63.

alternatives.[173] As one article states, "if plans compete on price, choice, and quality, they have incentives to cover services that yield expected health benefits that are worth their costs to consumers. Patients who want comprehensive coverage can choose high premium plans."[174]

Some assert that mandating benefits takes away the option of lower-priced insurance and forces consumers to pay for insurance they may not want or to go without coverage at all.[175] As one panelist noted, with mandates "you are banning what are in effect the low cost health insurance contractual alternatives … that should, in theory, begin to decrease insurance coverage at least on the margin particularly for price sensitive buyers."[176]

Panelists and commentators noted that it appears that legislative enthusiasm for a particular mandate may be based on an isolated anecdote, with little or no analysis of costs and benefits.[177] Mandates, as one panelist observed, may create an illusion of getting benefits for free.[178] Legislators may be motivated to pass mandates because they can deliver a benefit to consumers but not incur an on-budget cost. In general, tax revenues are not required to pay for the mandate, but the mandate is still a tax on consumers.[179]

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[173] RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 429 (1997).

[174] Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 509 (1997). *See also* David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 437 (1998) ("Policy sellers must weigh whether broadening coverage … [is] worth doing if [it] price[s] the policy out of the market – or result[s] in a shift in the nature of coverage from that which is most appealing to the covered pool as a whole.").

[175] Korobkin, *supra* note 162, at 22. *See also* Kanwit 6/25 at 28 (arguing that mandates "drive up the costs for employers and consumers", "may restrict consumer choice", "discourage competition among providers", and "stifle innovative medical advances in treatment and diagnosis because they freeze current practice.").

[176] T. Miller 6/25 at 57.

[177] *See, e.g.*, Kanwit 6/25 at 40 (describing the New England Journal of Medicine study that suggested that the mandated 48 hour maternity stay mandate did not help infant health); Hyman 6/25 at 87 (noting use of "horror stories" to set regulatory agenda); Clark Havighurst, *American Health Care and the Law: We Need to Talk!*, 19 HEALTH AFFAIRS 84, 105 n.7 (July/Aug. 2000) ("Nothing could be clearer, however, than that the signals that voters (consumers wearing a different hat and having less reason to think rationally or fully inform themselves) send to their representatives do not invite rational consideration of difficult trade-offs."); David A. Hyman, *Regulating Managed Care: What's Wrong With A Patient Bill of Rights*, 73 S. Cal. L. Rev. 221, 237-41 (2000).

[178] Gitterman 6/25 at 9 ("It's hard for any voter, consumer or worker to know for sure how he or she is being affected by what ends up being a confusing tax. This helps policymakers foster the illusion that benefits can be provided and no one bears the cost.").

[179] Uwe E. Reinhardt, *Health Insurance for the Nation's Poor*, 6 HEALTH AFFAIRS 101, 106 (Spring 1987) ("A pseudo-tax is a government-mandated fiscal transfer among private individuals, institutions, or business firms that can be referred to by a name other than tax and that does not flow through a public budget for which politicians can be held accountable."); DANIEL P. GITTERMAN & ROBERT NORDYKE, PROVIDING CREDIBLE INFORMATION AND IMPROVING HEALTH INSURANCE REGULATORY IMPACT ANALYSIS IN CALIFORNIA: A REPORT TO THE CALIFORNIA HEALTH CARE FOUNDATION 2 (1999).

Others note the need for many mandates may be questionable; health insurers have obvious economic incentives to offer the benefits that consumers desire and are willing to pay for – facts which cast doubt on whether most mandates are cost-justified.[180] Finally, according to some panelists and commentators, providers of the mandated benefit are usually the most vigorous proponents of legislation, making it more likely that the mandated benefit constitutes "provider protection" and not "consumer protection."[181]

One panelist noted compliance with mandates is difficult for employers and insurers operating in multiple states. When a carrier or employer wants to provide uniform benefits across its workforce, it must adopt an aggregation of the most restrictive provisions to ensure the offering complies with all states simultaneously.[182] Alternatively, the employer can create a self-funded employee benefit plan, which is not subject to state mandated benefits laws.[183]

Commentators and panelists stated that mandates also limit employers' ability to offer health insurance coverage.[184] One panelist described the employer as having a pie that has a limited number of dollars for health care coverage. Employers will eliminate other benefits to offset the cost of any mandated benefits.[185] According to several panelists, mandates increase premiums and decrease wages and other benefits employers might otherwise offer.[186]

Other commentators assert that state-imposed mandated benefits disproportionately affect small businesses because they are less able to avoid the costs of such mandates by self-insuring.[187]

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[180] Jensen & Morrisey, *supra* note 172, at 5. *See also supra* note 174, and accompanying text.

[181] *See, e.g.*, Kanwit 6/25 at 39-40 (describing the mandates for autologous bone marrow transplant (ABMT), a breast cancer treatment for women for which there were no clinical trials, many women died from the treatment, and ABMT was no more effective than the standard treatment); T. Miller 6/25 at 66; Jensen & Morrisey, *supra* note 172, at 5; Hyman, *supra* note 177, at 223.

[182] Knettel 6/25 at 76. Of course, these are the very employers that may be best able to avoid the state mandates by self-insuring.

[183] The Employee Retirement Income Security Act (ERISA) largely preempts self-insured plans from state mandates. Thus, an employer may avoid state regulation by providing its own insurance. *See supra* Chapter 5.

[184] Jensen & Morrisey, *supra* note 172, at 9-10.

[185] Knettel 6/25 at 73-75 (noting that each time a benefit is mandated that mandate "is going to be offset by a benefit reduction of equal or greater cost in some other area"). *See also* Sloan & Conover, *supra* note 172.

[186] *See* T. Miller 6/25 at 64 (noting that mandates "can also have offsetting effects in terms of lower wages, decreased employment, reduced generosity of fringe benefits as well"). *See also* Gitterman 6/25 at 18; T. Miller 6/25 at 57.

[187] As the costs of mandates rise, more firms seek to self-insure to avoid the added expense of state mandates, but some smaller businesses do not have the necessary capital to do so. *See* Jensen & Morrisey, *supra* note 172, at 10. As stop-loss insurance with low attachment points has made self-insurance available on a broader basis, this problem has become less significant.

Although determining the actual cost of an individual mandated benefit can be difficult, the aggregate cost of such mandates appears to account for a substantial percentage of premium cost.[188]

Finally, some commentators have noted the behavioral economic arguments in favor of mandated benefits are theoretical, and not based on empirical evidence regarding the performance of the health insurance market.[189] Mandate proponents presented no evidence that consumers demand insufficient health insurance, and there is some evidence that many consumers actually demand excessive health insurance.[190] Mandate proponents presented no evidence that government intervention is likely to improve the efficiency of health insurance benefit design, and there is some evidence to the contrary.[191]

3. Any Willing Provider and Freedom of Choice Legislation: A Case Study of Mandates

Any willing provider (AWP) laws require managed care companies to include in their networks any provider that is willing to participate in the plan in accordance with the plan's terms.[192] Freedom of choice (FOC) laws are similar to AWP laws, but are directed at consumers instead of providers.[193] Many states have adopted AWP and/or FOC laws for at least some health care providers.[194]

Commission staff has expressed concerns about AWP and FOC laws, noting that they could have anticompetitive effects and harm consumers.[195] These laws can make it more difficult

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[188] *See* Kanwit 6/25 at 37; Gitterman 6/25 at 15 ("One of the things that you have seen in the 1996 mental health parity debate is the incredible wide range of estimates from each of these different consulting groups. I think the costs were somewhere between zero and 8 percent.").

[189] *See generally* 6/26 at 6-105; Hyman, *supra* note 177, at 234-36.

[190] The substantial tax subsidy for employment-based health insurance encourages broader and deeper insurance coverage than would otherwise be the case. Pauly 2/26 at 98; Clark Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 69-71 (2002).

[191] *See generally* Hyman, *supra* note 177.

[192] Michael Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any Willing Provider' Regulations*, 20 J. HEALTH ECON. 955, 956 (2001).

[193] *See, e.g.*, *id*. ("[F]reedom of choice (FOC) laws . . . obligate plans to reimburse for care obtained from a qualified provider even if the provider is not a member of the network")

[194] *See, e.g.*, *id.* ("By one count, 34 states had enacted some form of FOC or AWP law by 1996").

[195] *See* FTC staff comments on proposed legislation that incorporated any willing provider or "freedom of choice" provisions in the following states: Rhode Island (Letter from Office of Policy Planning et al., to Patrick C. Lynch, Attorney General (Apr. 8, 2004)), *at* http://www.ftc.gov/os/2004/04 /ribills.pdf; Massachusetts (Letter from Bureau of Competition, to John C. Bartley, Representative (May 30, 1989)); New Hampshire (Letter from Office of Consumer & Competition Advocacy, to Paul J. Alfano (Mar. 17, 1992)); California (Letter from Office of Consumer

for health insurers to negotiate discounts from providers in exchange for the higher patient volume that likely would result from restricted provider networks.[196] They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in response to consumer demand.[197] These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans.

As Commission staff explained in its most recent advocacy letter on this issue,

> Empirical evaluations of any willing provider and "freedom of choice" provisions indicate that these policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider/freedom of choice laws spent approximately 2% more on healthcare than did states without such policies. This finding likely reflects the fact that these laws reduce the ability of insurers to offer less expensive plans with limited provider panels. This interpretation is supported by another study that found that metropolitan areas with a high intensity of any willing provider/freedom of choice regulation had HMO market shares approximately 7% lower than comparable areas without these provisions. "Freedom of choice" provisions reduced HMO market share more than any willing provider laws.[198]

Many provider groups support AWP and FOC legislation.[199] Commission staff observed in its most recent advocacy letter that "several scholars have noted that any willing provider and 'freedom of choice' laws are more likely to appear in states with limited managed care penetration, and suggested that these provisions are actually intended to preempt competition

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& Competition Advocacy, to Patrick Johnston, Senator (June 26, 1992)), *at* http://www.ftc.gov/opa/predawn /F93/calpharm.htm; Montana (Letter from Office of Consumer and Competition Advocacy, to Joseph P. Mazurek, Attorney General (Feb. 4, 1993)); New Jersey (Letter from Office of Consumer and Competition Advocacy, to E. Scott Garrett, Assemblyman (Mar. 29, 1993)); Pennsylvania (Letter from Office of Consumer and Competition Advocacy, to Roger Madigan, Senator (Apr. 19, 1993)); South Carolina (Letter from Office of Consumer and Competition Advocacy, to Thomas C. Alexander, Representative (May 10, 1993)); and Nevada (Letter from Bureau of Competition, to David A. Gates, Commissioner of Insurance (Nov. 5, 1986).

[196] *See, e.g.*, FTC Staff letter to Rhode Island, *supra* note 195, at 6; Greenberg 6/12 at 68-69.

[197] *See supra* note 196.

[198] FTC Staff letter to Rhode Island, *supra* note 195. *See also* Michael A. Morrisey & Robert L. Ohsfeldt, *Do State 'Any Willing Provider' and 'Freedom of Choice' Laws Affect HMO Market Share?*, 40 INQUIRY 362 (2003/2004).

[199] *See, e.g.*, Gene A. Blumenreich, *United States Supreme Court upholds "any willing provider" statutes*, 71 AANA J. 259 (Aug. 2003) (Legal Brief of American Ass'n of Nurse Anesthetists), *at* http://www.aana.com/legal/legbrfs /2003/pdfs/p259-262.pdf; American Medical Ass'n, *H-285.984 Any Willing Provider Provisions and Laws* (AMA policy re: "Any Willing Provider" laws, including opposing federal preemption of state AWP laws), *at* http://www.ama-assn.org/apps/pf_new /pf_online?f_n=browse&doc=policyfiles/HnE/H-285.984.htm (last visited June 25, 2004); National Community Pharmacists Ass'n, *High Court Upholds State Any Willing Provider Laws* (from AMERICA'S PHARMACIST, May 2003), *at* http://www.ncpanet.org /leg_gov/notes_from_capitol_hill/2003/may.shtml

among providers [provider protection], instead of protecting the interest of patients."[200]

4. Potential Responses to the Demand for Mandated Benefits

As the number of mandated benefits has risen, sensitivity to their cost ramifications has increased. The Unfunded Mandates Reform Act discourages Congress from imposing unfunded mandates on other governmental entities.[201] The states have developed a variety of strategies to weigh the costs of mandated benefits, with varying degrees of success.[202]

There are four basic models for mandatory review processes: (1) use of an independent standing health care commission or legislative advisory commission/interim committee; (2) use of an administrative agency; (3) use of legislative research or fiscal staff; and (4) use of proponent prepared and submitted assessments to the legislative committee.[203] Each model has procedural variations in the review process including how the bills are referred for evaluation and the specific requirements of the impact analysis. Some of the models may be more credible and provide more objective information than others.

Conclusion. For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay marginal cost. This task is challenging under the best of circumstances – and benefits are not mandated under the best of circumstances. In practice, mandates may limit consumer choice, eliminate product diversity, and raise the cost of health insurance. Mandates may also increase the number of uninsured Americans, as employers and employees opt out of the market.

State and federal policy makers should consider expressly factoring these risks into their decision making process, and develop ways of insulating the process of mandating benefits from their effects. Governments should reconsider whether current mandates, including AWP and FOC laws, best serve their citizens' health care needs.

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[200] FTC Staff letter to Rhode Island, *supra* note 195. *But see* Blumenreich, *supra* note 199 (noting that the American Association of Nurse Anesthetists (AANA) supports AWP legislation, arguing that these laws prohibit insurance companies from discriminating against them).

[201] CONGRESSIONAL BUDGET OFFICE, CBO'S ACTIVITIES UNDER THE UNFUNDED MANDATES REFORM ACT, 1996-2000 (2001), *available at* ftp://ftp.cbo.gov/28xx/doc2843/UMRA-Paper.pdf; Unfunded Mandates Reform Act (UMRA) of 1995, Pub. L. No. 104-4, 109 Stat. 48. The UMRA requires the Congressional Budget Office (CBO) to prepare an analysis of the direct costs of any mandates and an assessment of whether the bill authorizes or otherwise provides funding to cover the costs of the mandate.

[202] Gitterman & Nordyke, *supra* note 179.

[203] Gitterman 6/25 at 12-13.